HIV/AIDS Section Workgroup on ADAP
Meeting Summary
November 19, 2014

Representatives: Paul Arons, Jeffrey Beal, Martha Buffington, Jose Castro, Mike D'Amico, Earl Hunt III, Deidre Kelley, Kamaria Laffrey, Marlene LaLota, Joe May, James Talley, Bonnie Tiemann and George Timmer.

Guests: Ken Bargar, Jose Coscia, Jesse Fry, Jack Garcia Jr., Becky Gonzales, George Kress, Mark Nebel, Rebecca O'Hara, David Poole, DeePak Ranade, Allison Ruby, Michael Ruppal, Michelle Scavnicky, Suzanne Stevens and Melissa Walton.

Dr. Jeff Beal welcomed the representatives and guests and introduced Marlene LaLota, Administrator of the HIV/AIDS Section, Florida Department of Health.

Marlene LaLota provided an overview of her position and welcomed the representatives and guests who introduced themselves. She shared her work experience and explained that they recently changed the group's name to reflect more of a focus on HIV/AIDS. Previous names have started with AIDS Drug Assistance Program (ADAP); therefore, the current name is the "HIV/AIDS Section Workgroup on ADAP".

Dr. Paul Arons provided the historical perspective of the ADAP workgroup in an effort to set the tone for the new group and move forward. He encouraged the need to work together to include Hepatitis C as well HIV/Hepatitis C co-infection.

Dr. Jeff Beal introduced Joe May who provided an overview of the Patient Care and ADAP programs. A Power Point presentation was presented to the members.

Patient Care Update:

- Lina Saintus leads the Reporting Unit
- Laura Rumph leads the Community Programs Team
- Lorraine Wells leads the ADAP Program-Insured and uninsured programs
- Craig Reynolds and Cheryl Urbas comprise the HOPWA/Housing team
- Table of organization may change slightly in the future due to evolving programs such as shift of clients to Marketplace.

HRSA Update

- Requested technical assistance from National Quality Center to review Quality Improvement/Quality Assurance activities and offer suggestions on program improvement.
- 2015 ADAP Emergency Relief Funding (ERF) application-requested $11million-maximum you can receive-Moving forward FL may not qualify for ERF after 2015.
- 2015 Core Part B grant-due Monday, November 24, 2014-covers Part B base, Minority AIDS Initiative (MAI), Emerging Communities and ADAP Earmark
- No longer eligible for ADAP supplemental-do not have required cost saving or cost avoidance criteria. Loss of $8.6 million.
- Good news about the drug rebate collections that continue to grow and help with compensating for the loss of $8.6 million of ADAP Supplemental funds.
- From April 1, 2014 to present, about $15 million in rebates received.
- 2014 Part B Carryover funds request of $882,000 approved by HRSA

- HRSA Reverse site visit administrative meeting held in Bethesda, MD, November 5-7, 2014.
- Continue to be concerned about potential cuts to RW funds in light of ACA implementation
- Any potential cuts particularly to states that did not expand Medicaid very impactful.
- HRSA announced they would be conducting an ADAP site visit to Florida in late spring, 2015. Follow-up to 2013 ADAP visit with focus on movement of clients to the Marketplace.

HOPWA Updates

- Suspended HUD-sponsored technical assistance for the development of updated Florida HOPWA Policy and Procedures and Housing Needs Assessment tool to be restarted.
- Policy and Procedure Manual will include Tenant Based Rental Assistance (TBRA) program option.
- TA will include staff training component.
- HUD Regional office in Jacksonville approved request-waiting on TA provider to be given final approval to start.

A major project for 2015-2016 is to develop an integrated HIV/AIDS Prevention and Care Plan. Guidance should be released in the spring of 2015 for a due date of September 2016.

Joe provided an update on behalf of the ADAP program. Joe agreed to send the PowerPoint to Michelle Scavnicky to distribute the slides to the participants post meeting.

ADAP Updates:

- ADAP enrollment (22,404) and percentages (95%) served were reviewed as well as gender, race and ethnicity
- Clarification of the accuracy and confidence in the numbers was addressed.
- Interesting to see how the numbers compare to other programs that we collect and track data
- Suppressed viral load (less than 200-HRSA's scientific definition)-up to 90% of Florida ADAP clients achieved viral suppression. Compared to other states, we are doing a good job in this area.

Dr. Beal commented that this raises some really important questions: Why are we able to achieve 90% viral suppression in ADAP, but not in overall Patient Care?

Marketplace Clients 4,045

- 79% male, 21% female

Number of demanding priorities that inhibited the travel for ADAP staff:

- Marketplace opening-November 15th
- Working with The AIDS Institute on the plan analysis
- Working on ADAP Policies, Procedures and Expectations
- ADAP software-negotiations-fiscal vendor who will write the check for the benefits
- PBM activities are underway-subsequent competitive procurement in queue

- Wrapping up the software project-find out the lead software person

Discussion ensued in regards to the confusion around enrollment. The notification of changes that were staggered may have added to a layer of confusion, although were originally intended to assist with the client transition.

Marlene commented on the numerous tasks among staff and the willingness to address other concerns around client choice and encourage future discussions.

Joe May addressed having to revisit the current pharmacy benefits manager agreement and the pricing that exists –although we may need to wait until July 1st.

David Poole commented that we do not all want to go after the competitive procurement; we just want to understand and include pharmacy network diversity.

Dr. Jeff Beal commented that rebates are relied upon because other states are/may be getting more funding from their state legislature.

Clarification was provided on the role of a Pharmacy Benefit Manager versus the running of a state ADAP program? Joe May confirmed that AICP was not managing the clients transitioning to the Insurance Marketplace. AICP is more focused on employee-sponsored insurance providing a fairly stable program.

Clarification of the amount of General Revenue state support received ($10.5 million) and 2012 was last time we got an increase in funding.

Marlene confirmed that with approximately 3400 clients, PBM is reaching only a small subset of those clients. She explained that the approximate $20 million in rebates is facilitated by using the data managed by the PBM—didn't previously have the data sophistication to meet the reporting requirements to request rebates.

Marlene stressed the importance of having the clients use CVS Caremark in order to get the rebates. She commented that we will work to expand the pharmacy network and that this capacity is already noted when PBM services are re-solicited through a competitive procurement process.

It was suggested to have the formulary include the ancillary drugs.

Ken Bargar raised concern around Lorraine Wells comments at the April 2014 PCPG meeting about using only the CVS pharmacy.

Marlene clarified that we can encourage, but not demand or be prescriptive to people to only use the CVS pharmacy.

George Kress from Pharmacy commented that it may not always be the pharmacy. As a provider, the value of medication and treatment adherence is another area that needs to be considered.

Dr. Beal commented that there are a number of patients that lose private insurance and agreed that it could be the pharmacists that link people back to care.

Michael Ruppal clarified the amount of funding that Florida supports and explained a legislative budget request and sometimes it is the political nature of the issue versus comparison of other state funding.

Melissa Walton commented that to address viral suppression issues, it is often the relationship with the pharmacists. They are the ones that frequently get calls about specific drugs, etc.

Joe May addressed the criteria for the 4K plus clients to transition and the federal poverty level (FPL). This created an opportunity to maximize the federal subsidies and support. It was the most resource?? needed clients.

Joe explained that they are trying to examine the financial costs now of the plans to determine the impact.

Q: Is there any examination of folks that are reaching viral suppression?
A: No, only 10% aren't undetectable, may have not been on drugs long enough to demonstrate their viral suppression.

They have to be active ADAP clients, which would be that they are at least picking up medications.

Dr. Beal commented that we would need to monitor that issue as well (picking up medications).

Dr. Arons commented that those being transitioned out of the ADAP program are at the highest level of need; and the goal is to have them succeed in the marketplace, as they did in ADAP.

Q: How long would it take to transition the rest of the clients?
A: Approximately 3 years if funding is sustainable.

Q: What will happen to client "JoJo", if he is told he will transition?
A: The county health department ADAP staff will continue to be a focus for clients, gather their information and take care of the premium payment expenses. We need to look at technical issues like not paying insurance premiums past their eligibility deadlines. Envision paying it twice a year, similar to eligibility review. There is still an issue of out of pocket co-payment for medical appointments.

Joe alluded to development of policy language to ensure that local resources (Part A & B) are available to pay for the line item for co-payment. There is a possibility of a reallocation of funds as we move forward.

Michael Ruppal provided a brief legislative and plan analysis update. He discussed the plan complaint and explained that although they may have lowered the tier costs, they have made up for it with increased costs in other areas.

Dr. Beal and Dr. Arons provided a medical update.

Dr. Beal explained that the Glasgow conference was held earlier in November and the following updates were provided:

- New NNRTI on horizon-Doravirine versus Efavirenz
- PrEP guidelines-distribute via email.
- Infectious Diseases Society of America Guidelines
    - Major change-IDSA CKD in HIV guidance

A request was made to distribute Dr. Beal's PowerPoint slides to the representatives and guests of the meeting.

Dr. Arons provided an overview and update in regards to the ADAP crisis taskforce and the fair pricing coalition.

Fair Pricing Coalition:
Founding members: Martin Delaney (Project Inform) and Linda Grinberg-Linda died in 2002, AIDS activists

History

- Worked with ADAP Directors before creation of the ADAP Crisis Task Force (ACTF)
- First ever price freeze (2 years 2002)
- Resulted in $50MIL savings for ADAPs
- Currently works in conjunction with ACTF
- Involved in HCV in 2010

Programs and Initiatives

- Negotiates with HIV & HCV drug companies for:
    - Initial pricing after FDA approval
    - Price freezes and annual increases
    - List of members for both HIV and Hepatitis C

For more information: www.Fairpricingcoalition.org

Dr. Beal explained that part of what the HIV/AIDS Section Workgroup on ADAP does is the addition of new drugs to the formulary. An email will come from he and Dr. Arons explaining the pros/cons/side effects; and then call a meeting to conduct an electronic vote to make recommendations to the Section for adding drugs to the formulary. He explained that the goal is to look at cost neutrality when examining drugs.

Dr. Beal provided an update to the group about the new Pharmacy and Therapeutics Committee-recognizing an obligation to have drug formularies for programs. Goal is to develop best guidance for Part B's for safety and efficacy.

The plan is to reconvene the group and get a formulary together for the Part B/Lead Agencies. He explained that it would not be mandatory, but help by providing guidance.

Clarification was provided that some states operate as direct payment states or rebate states.

Workgroup Expectations:

- Goal of the committee: formularies, policy and services of the ADAP program
- Critical advisory body to the HIV/AIDS section
- Electronic meetings will occur
- Face to face may be more difficult-no less than once a year.
- There are still a few membership slots to fill
- Discussions and recommendations from this group will be taken seriously.

Discussion ensued in regards to consumer satisfaction surveys—done at a local level and often don't come back to the state.

Dr. Beal asked "Would surveys be something the group would want to review in the future?"

A suggestion to have a volunteer serve or assist the ADAP staff on the local level because it appears that since there are many things that are going on, they could be overstressed and this "volunteer" could help.

Joe May confirmed that Paul McKeel is the workgroup liaison from Tallahassee office.

Dr. Arons suggested building a list of who's who. What is the chain of command? Who would a client/patient call if they have an issue?

Marlene suggested providing examples of the types of issues to help determine how far you can take the question, if you are not satisfied with the answer.

Dr. Beal stated that you could start by calling the main ADAP line—reach program staff or you could call the ADAP workgroup liaison.

Dr. Beal presented the Bylaws and asked for comments to be submitted by **December 15th, 2014**. He stated that all Bylaw recommendations be sent to Annie Farlin using track changes. Annie's email is Annie.Farlin@flhealth.gov. (Also, make sure to thank her for the blue bag).

Additional comments:
A comment was made regarding a rural area perspective and that it would be nice to include a mail order component outside of Premium Plus or CVS Caremark. The issue is for the uninsured; due to an issue of transportation. 90 days is problematic if you are changing your regimen.

It was confirmed that with the new pharmacy and database, the option to select mail order or pharmacy would be a part of it.

Concerns were raised around the lack of communication distributed by central pharmacy. Communication in general needs to be addressed, especially around penalties.

Dr. Beal asked the participants to answer questions, etc. about ADAP program moving forward.

Is there patient tool kit available for a consumer to have to review, explains ADAP for them?

A suggestion was made to have ADAP information/fact sheets available for the clients.

It was confirmed that ADAP rights and responsibilities are available.

It was suggested to include ADAP information on all social media, Facebook, wemakethechange website and add resource documents there as well.

A suggestion was made to improve information dissemination overall.

Dr. Beal reminded the participants to submit their meeting evaluation forms.

A comment was made that although the ADAP policies and responsibilities are being modified within the manual to include AICP, AICP is not modifying their manual to include ADAP.

Joe May agreed to share the ADAP policies and procedures with the workgroup.

A suggestion was made to simplify the language for the ADAP consumer (i.e. Palm Cards).

Summary and Action Items:

1. Review Bylaws by Dec 15th and provide all comments to Annie Farlin at Annie.Farlin@flhealth.gov. Goal is to finalize the Bylaws by January 15th, 2015.
2. Dr. Beal will be sending the ADAP data to be reviewed and provide comments/feedback on improvements/changes.

Dr. Beal asked the participants to watch for emails to come from Debbie Taylor and Roxanne Sieks-the two nurses in the HIV/AIDS medical section. Debbie is the lead nurse for the ADAP program.

A question was raised regarding Haitian, black or non-Hispanic ethnicity and the “other” representation as it relates to ethnicity breakdown among the ADAP transition clients. Joe May confirmed that it is the way that HRSA reports the breakdown.

No further business to discuss, the meeting ended at 3:30PM.